



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Shannon Medical Center

Respondent Name

Travelers Indemnity Co of Connecticut

MFDR Tracking Number

M4-16-2425-01

Carrier's Austin Representative

Box Number 5

MFDR Date Received

April 13, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Shannon Medical Center to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine is the correct allowable per the APC allowable per the new fee schedule that started 3/01/2008..."

Amount in Dispute: \$3,945.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the bill and disagrees that the services qualify for outlier reimbursement. Further, the Carrier contends the Provider has been properly reimbursed in accordance with the HCN contract."

Response submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 11, 2015	Outpatient hospital services	\$3,945.04	\$3,945.04

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers compensation jurisdictional fee schedule adjustment
 - W3 – Additional payment made on appeal/reconsideration
 - 107 – Claim/service denied because the related or qualifying claim/service was not previously paid or iden
 - 97 – Allowance included in another service

Issues

1. Is the Carrier's denial supported?
2. What is the Medicare payment rule?
3. What is the applicable rule that pertains to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier denied multiple claim lines as CVTY – “The charges have been priced in accordance to a Coventry owned contract.” Review of the TX COMP System found no indication that the injured worker is enrolled in any certified healthcare network. Therefore, this reduction will not be considered in this review. Denial code, 97 – “Allowance included in another service” was also used by the Carrier. 28 Texas Administrative Code 134.403 (d) states in pertinent part,

For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...

The following claim lines were reviewed as follows:

- Procedure code A4338 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 36415 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 83605 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 80053 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 80320 has status indicator B denoting codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.
- Procedure code 82550 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 83735 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 84100 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code G0431 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 82805 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 85025 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 85610 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code 85730 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 81001 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 99292 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Per Medicare policy, procedure code 71010 may not be reported with procedure code 74177 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Per Medicare policy, procedure code 36600 may not be reported with procedure code 99291 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Per Medicare policy, procedure code 96365 may not be reported with procedure code 74177 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Per Medicare policy, procedure code 96375 may not be reported with procedure code 74177 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Per Medicare policy, procedure code 96375 may not be reported with procedure code 71260 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code 96376 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 96376 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7030 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1953 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 90715 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

Pursuant to Rule 134.403(d) the carrier's denial is supported.

2. The remaining services in dispute are for Outpatient Hospital Services with dates of service August 11, 2015. 28 Texas Administrative Code 134.403 (f) states in pertinent part,

The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register.

The Medicare facility specific reimbursement amount is explained at, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctshst.pdf> as:

"The payment rates for most separately payable medical and surgical services are determined by multiplying the prospectively established scaled relative weight for the service's clinical APC by a conversion factor (CF) to arrive at a national unadjusted payment rate for the APC. The scaled

relative weight for an APC measures the resource requirements of the service and is based on the geometric mean cost of services in that APC. The CF translates the scaled relative weights into dollar payment rates.

To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) **is further adjusted by the hospital wage index** for the area where payment is being made. The remaining 40 percent is not adjusted. You may also receive the following payments in addition to standard OPPS payments:"

The facility specific reimbursement amount is calculated as follows:

Payment rate found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html>
Geographic adjustment

Procedure Code	APC	Status Indicator	Payment Rate	60% labor related	2015 Wage Index Adjustment for provider	40% non-labor related	Payment
70450 70486 71260 74177 72128 72131 72125	8006	S	\$528.56	\$317.14	0.866 X \$317.14 = \$274.64	\$528.56 x 40% = \$211.42	\$274.64 + \$211.42 = \$486.06
99291	617	S	\$656.94	\$656.94 x 60% = \$394.16	0.866 X \$394.16 = \$341.34	\$656.94 x 40% = \$262.78	\$341.34 + \$262.78 = \$604.12
G0390	618	S	\$889.32	\$889.32 X 60% = \$533.59	0.866 X \$533.59 = \$462.09	\$889.32 X 40% = \$355.73	\$462.09 + \$355.73 = \$817.82
90471	0437	S	\$53.54	\$53.54 X 60% = \$32.12	0.866 X \$32.12 = \$27.82	\$53.54 X 40% = \$21.42	\$27.82 + \$21.42 = \$49.24

The Medicare Claims processing Manual defines the terms, Status Indicators, APC Payment Groups and Composite APCs as follows:

10.1.1 - Payment Status Indicators

An OPPS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. For example, services with status indicator A are paid under a fee schedule or payment system other than the OPPS. Services with status indicator N are paid under the OPPS, but their payment is packaged into payment for a separately paid service. Services with status indicator T are paid separately under OPPS but a multiple procedure payment reduction applies when two or more services with a status indicator of T are billed on the same date of service.

The full list of status indicators and their definitions is published in Addendum D1 of the OPPS/ASC proposed and final rules each year. The status indicator for each HCPCS code is shown in OPPS Addendum B.

10.2 - APC Payment Groups

Each HCPCS code for which separate payment is made under the OPSS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. (See section 10.5 for discussion of multiple procedure discounting under the OPSS).

10.2.1 - Composite APCs

Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.

The Medicare Claims Processing manual, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf>, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPSS), Section 10.7 states, in pertinent part,

“Beginning in CY 2005, for hospitals only, CMS implemented the use of a fixed-dollar threshold to better target outlier payments to complex and costly services that pose hospitals with significant financial risk. The current hospital outlier policy is calculated on a service basis using both fixed-dollar and multiple thresholds to determine outlier eligibility.

The current outlier payment is determined by:

- *Calculating the cost related to an OPSS line-item service, including a pro rata portion of the total cost of packaged services on the claim and adding payment for any device with pass-through status to payment for the associated procedure, by **multiplying the total charges for OPSS services by each hospital’s overall CCR** (see §10.11.8 of this chapter); and*
- *Determining whether the **total cost for a service exceeds 1.75 times the OPSS payment and separately exceeds the fixed-dollar threshold determined each year; and***
- *If total cost for the service exceeds both thresholds, the outlier payment is 50 percent of the amount by which the cost exceeds 1.75 times the OPSS payment.*

The total cost of all packaged items and services, including the cost of uncoded revenue code lines with a revenue code status indicator of “N”, that appear on a claim is allocated across all separately paid OPSS services that appear on the same claim. The proportional amount of total packaged cost allocated to each separately paid OPSS service is based on the percent of the APC payment rate for that service out of the total APC payment for all separately paid OPSS services on the claim.”

3. 28 Texas Administrative Code 134.403 (f) states in pertinent part,

The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPSS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific

reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

Review of the submitted medical claim finds implants were not requested. The maximum allowable reimbursement for the services in dispute listed on DWC 60 is calculated as follows:

- Procedure code 86850 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date.
- Procedure code 86900 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date.
- Procedure code 86901 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date.
- Procedure code 72170 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date.
- Procedure code 73090 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date.
- Procedure code 73060 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date.
- Procedure code 99291 has status indicator Q3 denoting conditionally packaged codes that may be paid through a composite APC if OPPS criteria are met; however, review of the submitted information finds that the criteria for composite payment have not been met. The total Medicare facility specific reimbursement amount for this line is \$656.94. This amount multiplied by 200% yields a MAR of \$1,313.88.
- Procedure code G0390. The total Medicare facility specific reimbursement amount for this line is \$889.32. This amount multiplied by 200% yields a MAR of \$1,778.64.
- Procedure code 90471. The total Medicare facility specific reimbursement amount for this line is \$53.54. This amount multiplied by 200% yields a MAR of \$107.08.
- Procedure codes 70450, 70486, 71260, 74177, 72128, 72131, and 72125. This line is assigned status indicator S denoting a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$2,775, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.178. This ratio multiplied by the billed charge of \$20,648.00 yields a cost of \$3,675.34. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of \$528.56 divided by the sum of all APC payments is 24.83%. The sum of all packaged costs is \$1,187.46. The allocated portion of packaged costs is \$294.90. This amount added to the service cost yields a total cost of \$3,970.24. The cost of these services exceeds the annual fixed-dollar threshold of \$2,775. The amount by which the cost exceeds 1.75 times the OPPS payment is \$3,045.26. 50% of this amount is \$1,522.63. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is \$2,051.19. This amount multiplied by 200% yields a MAR of \$4,102.38.

4. The total allowable reimbursement for the services in dispute is \$7,301.98. The amount previously paid by the insurance carrier is \$2,833.90. The requestor is seeking additional reimbursement in the amount of \$3,945.04. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$3,945.04.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$3,945.04 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	May , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.